

Office of Administration
Commissioner's Office

"Request for Preauthorization for Other Services"

Program: **Alternatives to Abortion**

Contractor: Nurses for Newborns

Subcontractor: N/A

Please enter below the information for each item/service to be purchased. List the date of purchase, item to be purchased, cost for the item, and the justification. Items must be approved **before** purchased/provided to be reimbursed.

Client Name: [REDACTED]

Date Enrolled: _____

Proposed Purchase Date	Item	Total Cost (include formal estimate from provider of services)	Justification, include other sources of funding that have been attempted
Due 3/20/17	Car Payment	\$247.76	Client has just returned to work & uses car to get to and from
AMOUNT TO BE REIMBURSED		\$247.76	

Please return to Alternatives to Abortion Program Manager, State of Missouri - Office of Administration, Commissioner's Office, State Capitol Building, Room, 125, Jefferson City, MO 65101. May be faxed to 573/751-1212 or emailed to emily.kraft@oa.mo.gov by the Contractor only!

Thank you.

Authorized person requesting purchase: _____

Jenny Uhlig

Approved for purchase: _____ Date _____

Purchase denied: _____ Date _____

Reason for denying purchase: _____

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ALTERNATIVES TO ABORTION PROGRAM
Assistance Request

This form is to be completed by an NFN Nurse ONLY and must be completed entirely for timely approval and submission.

DATE: 3/17/17 CLIENT NAME: 

The above named client is requesting assistance through NFN's ATA Program for the following:

 Rent
(if new request, a W-9 and Lease MUST accompany this form)

☒ **Transportation**
(if new request, no additional information is needed; if repeat request for gas card ONLY, please provide receipts)

 Utility
(if Ameren, provide account number and account holder's name; if Laclede, provide bill)

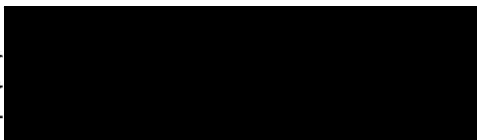
 Other
(Pre-Authorization Request and documentation of the bill/invoice/etc. to be paid MUST accompany this form)

Landlord/Utility/Other NAME: Midwest Acceptance

BILL TOTAL: \$ 247.76 AMOUNT YOU ARE PAYING: \$ 40 AMOUNT REQUESTED: \$ 207.76

OTHER RESOURCES ATTEMPTED FOR ASSISTANCE (must list at least three):

- 1.
- 2.
- 3.



Agency Representative: _____
Agency Representative: _____
Agency Representative: _____

*I understand this is a one-time payment. This assistance is intended to assist you in the delivery of a healthy baby or in keeping your child on target developmentally. I have completed a **Budget Form** and **Individualized Pregnancy Continuation Plan (IPCP)** with my nurse in order to ensure my ability to pay*



3/17/17
(date)

[Signature]
(RN signature)

3/17/17
(date)

IPCP Completed/Submitted: JV (initial)

Budget Form Completed: JV (initial)

Date Received: _____ Date Pledged/Submitted for Payment: _____